Telehealth Workgroup Minutes

Office of Health Information Technology
James R. Thompson Center, 100 W Randolph, 2-201
December 13th, 2011; 10:00 AM
877.402.9757 / PC 4269321

Participants:

Name	Organization
On the Phone	
Glenn Groesch	Southern Illinois University (SIU) School of Medicine
Joshua Sarver	SIU School of Medicine
In Person	
Sunil Hazaray	American Telemedicine Association (ATA)
Sharron Matthews	Illinois Department of Healthcare and Family Services (HFS)
Laura Zaremba	Illinois Office of Health Information Technology (OHIT)
Mary McGinnis	OHIT
Ian Bertorelli	OHIT

Sunil Hazaray (Sunil) took role call and preformed introductions. He motioned to approve the minutes from the last meeting. **Mary McGinnis** seconded the motion, and the minutes were approved.

Mary gave an update on the state of the Illinois HIE (ILHIE). She announced that ILHIE Direct, the state's secure messaging service, has officially been launched and already has more than sixty users. A "hard launch" is scheduled for some time this week. The testing that was being preformed over the last month will continue in order to gauge how providers will use the service. **Mary** mentioned that a group of long term care facilities have come forward and expressed intentions to use ILHIE Direct to facilitate transitions of care by exchanging discharge summaries with their hospital partners; she anticipated that this would become an important use case for ILHIE Direct and said that OHIT would be in close contact with those providers to explore that further. In other news, OHIT was awarded a grant from SAMSHA and HRSA to integrate medical and behavioral health information and to educate behavioral health providers about the exchange of clinical information. ILHIE Direct is positioned to be the mechanism for that exchange: most behavioral healthcare providers do not have EHR systems, ILHIE Direct is being offered at no cost to all Illinois providers through 2012, and provider-to-provider communication has fewer consent issues surrounding it than robust HIE record sharing does. **Mary** then gave an update on the core services. OHIT is talking with its alpha partners to begin the onboarding process, as well as engaging in discussion with HFS regarding state assets that could be used to build the provider directory and master patient index. She mentioned that the three whiteboard sessions to date have been successes and brought together ILHIE's many stakeholders in discussion. **Laura Zaremba (Laura)** echoed her reminder from the last meeting that the ILHIE core service implementation is operating under the recommendations that the work group made for consideration by the ILHIE Advisory Committee, and that the group is being looked to as the state's subject matter experts. In the event of any unforeseen changes in the state's telehealth landscape, **Laura** asked that the recommendations be kept current so that the implementation is informed by the most recent views that the group has to offer. **Sunil** asked if ILHIE Direct could function as an EHR for those behavioral healthcare providers that do not have EHR systems. **Laura** replied that its functionality is limited to secure, point-to-point transfers of information, and would not be able to store health records. However, she anticipated that the work OHIT will be doing in the coming year on the behavioral health grant could identify some behavioral healthcare providers who are interested in taking the next step, perhaps towards an EHR-lite solution.

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Glenn Groesch (Glenn) introduced **Sharron Matthews (Sharron)** and invited her to give her presentation on HFS's Care Innovations project. Sharron started by giving an overview of what she described as a "sea change" in Medicaid delivery, and said that the healthcare reforms happening at the national level are now being paralleled by reforms happening in Illinois. She directed the group's attention to the Medicaid Reform Legislation Fact Sheet, then used it to highlight some key elements of the law, and give a survey of Illinois's Medicaid landscape. Firstly, the new legislation states that 50% of the state's Medicaid population must be moved into "coordinated care" by 2015; this number is around 1.5 million people. Secondly, HFS and its sister agencies, the Illinois Department of Human Services and the Illinois Department on Aging, are required to create a unified budget to facilitate community-based delivery of long term care for patients coming out of institutions that the state has traditionally relied on for this care delivery. The state simultaneously expects somewhere between 500,000 and 800,000 new Medicaid enrollees once federal healthcare legislation expands Medicaid eligibility in 2014. **Sharron** familiarized the group with HFS's definition of care coordination, included on slide 9 in the Care Innovations Project power point deck. **Sunil** noted that the definition closely resembles that of the Accountable Care Organizations (ACOs) described in the Affordable Care Act (ACA). **Sharron** confirmed that the model is based on the ACA's outlines for ACOs, but only requires a care network to cover 500 Medicaid beneficiaries for three years, as opposed to the federal requirement of 5,000 Medicare beneficiaries for the same period. She emphasized that the state will be sharing risks and savings with providers under this new model. She called attention to slides 13 and 14 of the Innovations Overview power point: the definitions of the two new care coordination networks the state seeks to create. Coordinated Care Entities (CCEs), will be networks comprised of primary care providers, inpatient/outpatient facilities such as hospitals or clinics, mental health providers, and substance abuse providers. These networks will provide holistic, community-based wrap-around service to patients. **Sharron** noted that the project brings mental health and substance abuse providers to the table for the very first time, and said that this partnership would be an important part of creating the type of care necessary for those transitional services. CCEs will be funded for ten years and expected to demonstrate savings or cost neutrality at the end of that period. The other care networks that the state has outlined, Managed Care Community Networks (MCCNs), will be formed by larger entities such as county governments or medical schools and will have different financial structures to accommodate their larger size.

Mary asked how telehealth providers in specific could take advantage of these initiatives. **Sharron** replied that telehealth providers will have to become partners in the networks that form, as individual providers will no longer be able to deliver Medicaid services outside of these networks once they are established. The networks will submit a letter of intent to HFS by February 29, followed by full proposals on May 25. The Innovations Project will be launched in two phases: in phase one, the smaller provider networks will form the CCEs, and in phase two, the larger hospitals and HMOs will form MCCNs. **Sharron** drew a distinction between these networks and the Integrated Care Networks (ICNs) that were set up last year: Aetna and Centene-IllinCare were asked to establish and manage ICNs, but the Innovations Project asks groups to come forward with their networks already intact. Again, telemedicine providers should be seeking to partner with groups who intend to submit proposals. She then directed the group's attention to the three URLs in the body of Director Hamos's memo about the project's RFP. The third URL, http://www2.illinois.gov/hfs/PublicInvolvement/cc/mm/Pages/SubmitMatchmaking.aspx, is for HFS's Care Coordination Matchmaker site, where organizations that have voiced interest in

collaborating on these networks can list themselves by geographic area and interest. **Sharron** invited the work group members to visit the Matchmaker site, and reminded them that providers may be a part of as many networks as they have the capacity to deliver service to. Since 42% of Illinois' Medicaid population lives in Cook County, and an additional 14% resides in the collar counties, most of these networks will be in the greater Chicagoland area so the state can meet its mandated objective of covering 50% of enrollees by 2015. **Sharron** stressed that this paradigm shift in the state's Medicaid program will be happening regardless of the US Supreme Court's decision on federal healthcare reform.

Sunil thanked **Sharron** for explaining how telehealth providers can become part of this initiative. He wondered if ILHIE Direct could have a role in the project, and asked if network partners were mandated to have HIE connectivity. **Sharron** said the CCEs were expected to have some form of HIE functionality during their first twelve months and be fully HIE ready at the end of that period. She felt that ILHIE Direct would be an important tool that small providers could use to meet the connectivity requirements of that first year, especially for behavioral health providers as they were not included in the federal EHR incentive payments. She said the challenge for telehealth providers would be to identify these groups, partner with them, and educate them on the emerging HIE services and the added value of telemedicine to their programs. Because the program describes ten-year partnerships, HFS predicts the CCEs will grow into MCCNs. **Sharron** reiterated that the Care Innovations Project will use healthcare as an economic engine to deliver shared savings to what will eventually become healthier communities. **Laura** asked for clarification on whether or not the telehealth providers that did not presently have the necessary relationships in place would have an opportunity to join a CCE down the line. **Sharron** answered that providers would have two chances to join a network, once during phase one, and once during phase two, but she encouraged providers to join the discussion and begin developing relationships presently. She said that HFS would be working with the Chicago Community Trust to organize webinars that will cover telemedicine and HIE, as well as other topics. **Mary** asked when these webinars would be, to which **Sharron** replied that they were scheduled in early March. **Mary** brought up **Laura's** point from earlier that the work group members are considered by the state to be the subject matter experts and encouraged **Sharron** to tap them as a resource for these webinars. **Sunil** mentioned that he is a board member of the ATA, and could draw from their expertise as well. **Sharron** thanked him, but said that HFS did not want to appear to be endorsing the ATA, to which **Sunil** clarified that the association is comprised of institutions and universities that periodically convene to discuss telemedicine issues. **Sharron** thanked him again, and acknowledged it as an opportunity. She went on to discuss the project's timeline. HFS will be reviewing the proposals and making announcements during the summer months. The fall contract negotiations are expected to be completed by November, with the programs officially starting in January of 2013. Again, she referenced Director Hamos's RFP memo and asked the work group members to visit the first link, http://www.purchase.state.il.us/ipb/IPBhomep.nsf?Open, to learn more about the solicitation. The second link, http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx is where interested parties should go to get more information on the initiative, see the timeline, and register for project announcements such as Director Hamos's memo. **Glenn** requested that these links be redistributed to the group, which **Ian Bertorelli (Ian)** volunteered to take care of.

Glenn then described the front page of Sunday's State Journal Register in Springfield, and said that there were two items that tied into issues that **Sharron** touched on. The first was an article announcing that the Jacksonville Developmental Center will be one of the mental health

facilities the state is planning to close, the second is a photograph of Director Hamos discussing the Medicaid's funding shortfalls. **Glenn** said that SIU is disappointed that the state is closing the Jacksonville Developmental Center, not just because it is one of SIU's telemedicine clients, but also because transferring the center's patients usually causes major disruptions in care. He said that, in the second article, Director Hamos elaborated on funding shortfalls and building shortfalls and discussed reductions in reimbursements. Glen related an anecdote about a cardiologist he is acquainted with who remarked that it was not profitable for him to stay in business in light of the upcoming Medicare and Medicaid cuts. He asked **Sharron** where the patients from the Developmental Center were expected to go after it closed in light of decreasing options for the developmentally disabled. **Sharron** said that the state is doing its best to maintain services for as many individuals as they can in a time of extreme fiscal pressure. In response to the comment made by the cardiologist, **Sharron** reminded the group that medicine is a business and healthcare's current situation is a reality, and said that Medicaid has a 24% share in Illinois' healthcare market, with indications that number will rise to 30% soon. The coordinated care model is how Medicaid services will be delivered in Illinois; providers will have to make a business decision on whether or not they will continue to work with the state to deliver care in that market. In response to **Glenn's** query about the relocation of the Jacksonville patients, **Sharron** acknowledged the massive effect that the closure of the facility will have on the community. She said that the state has recently won three lawsuits related to developmental disabilities and has been working on a plan to transition capable individuals to the coordinated care networks that will be created by the Innovations Project and move the rest to other institutions. Reiterating her earlier point about the business elements of medicine, **Sharron** clarified for the group that the CCEs and MCCNs were not a replacement for an older model but sought to create a much larger business opportunity for industries such as telehealth. **Sunil** described what he perceived an overall paradigm shift in both Medicaid and Medicare payments from volume-based to value-based. **Sharron** agreed, adding that the state is changing hospital rates for precisely that reason. The group's consensus was that coordinated care from a community perspective as a concept was not new, (perhaps as much as fifteen years old), but that the technology to make it a reality has only recently come into existence. **Sharron** concluded her presentation.

Sharron mentioned that Director Hamos felt that HFS was not "telemedicine ready" and needed to be for the activities the agency is undertaking, and had instructed her to explore how HFS can integrate telehealth providers into their process. **Sunil** and **Glenn** invited **Sharron** to attend the work group meetings going forward. **Joshua Sarver (Josh)** thanked **Sharron** for her presentation, and echoed her points about care coordination's role in both state and federal models. He said that the ACA mentioned telehealth directly in the sections on the Medicare Shared Savings Program and ACOs, and took this as an indication that telemedicine would be a key component of care coordination—not just in provider-to-patient communications, but also provider-to-provider communications. **Sharron** asked if the group would be able to prepare a summary on how telemedicine could be integrated into the project, offering to pass on information on how members could get involved in the upcoming Community Trust-sponsored webinars. **Sunil** offered to pass on the three telemedicine use cases the work group developed and their accompanying whitepaper, and suggested that the group could develop a study on how telemedicine and telehealth could be used in a broader framework for the Care Innovations Project. **Mary** suggested looking at HFS's Matchmaker website to see if any telemedicine programs have already come to the table, as opportunities may exist to expand the roles of existing organizations. **Glenn** agreed, saying he felt that would be a natural progression of the work the group is doing. **Sunil** invited **Josh** to join him and **Glenn** on that project. **Sharron**

suggested that that material could be presented at the webinar. **Josh** accepted the invitation, saying that it is already aligned with work he has been doing analyzing the ACA. He suggested possibly utilizing federal plans for ACOs as written in the law as a guide for the study. The work group applauded **Josh** for his familiarity with the 1,000-page plus act.

Once more, **Sunil** thanked **Sharron** for her presentation. He noted that the hour allotted for the meeting had elapsed and asked the group if they felt the outstanding agenda items should be tabled until the next meeting. **Glenn** felt that was the best course of action, but said that the group still needed to discuss **Sunil's** presentation of the use cases to the ILHIE Advisory Committee. **Glenn** expressed the opinion that the presentation, which was tentatively scheduled for February 14, should be deferred until the Committee's meeting on April 3 in order to allow for some preparation. **Mary** agreed, and asked to be included in the preparations so that she could better understand the use case summary table that **Glenn** and **Sunil** prepared. **Sunil** asked **Ian** to schedule a conference call sometime before the next meeting, and suggested arranging a separate call between Josh, Glenn, and himself to discuss strategic visioning for the telehealth in the Care Innovations Project.

Mary invited members of the public present or on the phone to comment or ask questions. There were none.

Sunil thanked **Sharron** again for her presentation. **Glenn** echoed his thanks, let the group know that the next scheduled meeting is March 6, then moved to adjourn the meeting. **Josh** seconded the motion.

The meeting was adjourned.